Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RHD MEMORIAL MEDICAL CENTER
PO BOX 809053
DALLAS TX 75380

Respondent Name

ARGONAUT SOUTHWEST INSURANCE CO

Carrier's Austin Representative Box

Box Number: 17

MFDR Tracking Number

M4-04-4471-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier remitted $2,236.00 and deemed it to be fair and reasonable. In the Commissions determination marked by Tracking Number M4-02-3344-01, the Commission placed the urbrden [sic] on the Carrier to prove fair and reasonable by submitting to the recipient provider, charges of other providers which, would support the Carrier's reimbursement. In this case, Carrier has chosen not comply with the Commission's wishes indicating contempt for the Commission. Provider hereby submits an EOB for another Carrier recommending 85% reimbursement for the same or similar diagnosis. Provider contends it is fair and reasonable for provider to expect what other Carriers within the same jurisdiction of the Commission have seen fit to. [sic] reimburse. Further Carrier has received providers appeal by certified mail on July 10, 2003 as acknowledged by the U.S. Post Office. However to this day the appeal received and acknowledged has not been processed. Provider hereby seeks relief by way of order to Carrier to pay amount in dispute above. "

Amount in Dispute: $12,852.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: "Original review reflects a fair & reasonable reimbursement. Carrier has deemed $2236.00 as usual & customary allowance which has been consistently been applied and accepted by many providers for the similar service/procedure – consequently, past MDR decision per TWCC have been in favor of the carrier. Hence, no additional allowance has been warranted. Pls. note that all other service performed on the same to be considered as global fees."

Response Submitted by: Argonaut Southwest Ins., PO Box 152007, Irving, TX 75015

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2002	Outpatient Surgery	$12,852.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 17, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 22, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No MAR, reduced to fair & reasonable.
   - O – Denial after reconsideration

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Provider hereby submits an EOB for another Carrier recommending 85% reimbursement for the same or similar diagnosis. Provider contents it is fair and reasonable for provider to expect what other Carriers within the same jurisdiction of the Commission have seen fit to reimburse."
   - In support of the requested reimbursement, the requestor submitted one redacted explanation of benefits from one Carrier. However, the requestor did not discuss or explain how the sample EOB support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOB is for services that are substantially similar to the service in dispute. The carriers' reimbursement methodologies are not described on the EOB. Nor did the requestor explain or discuss the sample carrier methodologies or how the payment amount was determined for the sample EOB. The requestor did not discuss whether such payment was typical for such service or for the service in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		January 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.